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	09G181	A. BUILDING _____ B. WING _____	08/17/2007

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METRO HOMES	5721 13TH STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from August 15, 2007 through August 17, 2007. The survey was initiated using the fundamental survey process. A random sample of two clients were selected from a population of four males with various degrees of disabilities. The findings of this survey were based on observations at the group home, one day program, interviews at both the group home and day program, review of clinical and administrative records to include the facility's unusual incident reports.	W 000		
W 126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on the review of clients' financial assessments and interviews with direct care staff, the facility failed to demonstrate that clients were granted their rights to manage their financial affairs and to be taught to do so to the extent of their capabilities for two of the two clients in the sample. (Client s#1 and #2) The findings include: 1. Review of Client #1's Individual Financial Plan (IFP) dated May 3, 2007 revealed a money management program objective that the client, "will make purchases at the community store with 50% independence by March 2008".	W 126		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan J. Sloan RN, BSN, MA — TITLE: VP — (X6) DATE: 9/6/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 126	Continued From page 1 Interview with the Qualified Mental Retardation Professional (QMRP) indicated that the client goes to the store and selects items for purchase. Review of the client's IPP dated March 8, 2007 revealed no evidence of program objective for the client to manage his financial affairs and teach him to do so to the extent of their capabilities. 2. On August 15, 2007 at 5:45 PM, Client #2 was observed pulling a dollar from his pants pocket. Interview with the client stated, "I'm going to the store to get a diet soda". The direct care staff indicated that the client needed some additional money to purchase a can of soda and that the staff would provide the money. Review of the client clinical record included an IFP dated March 11, 2007. A goal was recommended that the client make purchases at the community store with 50% independence by March 2008. According to the IPP dated March 8, 2007 there was no evidence of program to teach the client to do so to the extent of their capabilities.	W 126	W 126 Client #1 and client #2 have had their money management IPP revised to ensure that the objective is appropriate and facilitates the client to use their capabilities to their fullest potential. In the future the facility will ensure that the IPP is written in context with the skills assessment. The Agency has instituted a QMRP monthly audit system. All staff has been in serviced on the IPPs for the 2 clients. See attached IPP and in service sheets, QMRP audit record	9/12/07
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that two of the two clients in the sample had underclothes in good repair. (Clients #1 and #2) The findings include:	W 137		

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W 137	Continued From page 2 1. On August 15, 2007 at 5:25 PM, Client #2 invited the surveyor to his bedroom. The client pointed to his personal belongings in both his dresser draws and closet. The client's underclothes had brown stains and were dingy in color. Further observations revealed that three pairs of underpants had another clients initials written in them. Interview with the client indicated that the underwear belonged to another client and he would return them to him. 2. During the environmental inspection on August 17, 2007 at 1:10 PM, Client #1's underwear were observed with brown stains and dingy in color. Interview with the Qualified Mental Retardation Professional (QMRP) acknowledged during the inspection that the clients underwear were dingy.	W 137	W 137 Clients #1 and #2 have had new underwear purchased. The staff has been in serviced on client's rights and laundry and care of personal items and clothing. In the future the facility will ensure that a monthly inspection of client's belongings is completed by the management in the homes. See attached in service sheet and monthly audit sheet	9/12/07
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the individual program plan (IPP) included objectives to meet the client's needs for two of the two clients in the sample. (Clients #1 and #2). The findings include: 1. The facility failed to develop and implement an IPP to address Client #1's needs as identified by the comprehensive assessment.	W 227		

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W 227	Continued From page 3 On August 15, 2007, Client #1 was observed with missing teeth. Record review of the dental consultation dated May 22, 2007 revealed that the client had four teeth extracted due to poor oral hygiene. Interview with the Qualified Mental Retardation Professional (QMRP) on August 17, 2007 indicated that the client needs assistance to thoroughly perform the task of toothbrushing. According to the Individual Support Plan dated May 3, 2007, the client need assistance with activities of daily living. The IPP failed to identified programs to address the clients needs. There was no evidence of a training program in this area. 2. The facility's QMRP failed to develop and implement a program objective teach client's to manage their financial affairs to the extent of their capabilities for two of two clients include in the sample. (Clients #1 and #2) [See W126]	W 227	W 227 1. - The IPP for client #1 regarding tooth brushing has been revised to ensure the client is assisted during this procedure. The staff has been in serviced and an in service on dental hygiene and tooth brushing and dental care has been completed by the nurse. See attached – in service sheet and IPP on tooth brushing	9/12/07
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients' individual program plans (IPP) included training in personal skills in both formal and informal setting	W 242	W 242 Refer W 227	

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W 242	Continued From page 4 for one of the two clients in the sample. (Client #1) The findings include: Interview with the Qualfied Mental Retardation Professional on August 16, 2007 at approximately 11:00 AM revealed that the client requires assistance to thoroughly brush his teeth. Review of Client #1's dental consultation dated May 22, 2007 revealed that the client had four teeth extracted due to poor oral hygiene. According to the client's nursing assessment dated April 30, 2007 revealed that the client had poor oral hygiene. The nursing assessment was reviewed quarterly (1/15/07, 4/12/07 and 7/10/07) and further indicated poor oral hygiene. Record verification of the IPP dated May 3, 2007 failed to identified a toothbrushing program.	W 242	W 242 - The IPP for client #1 regarding tooth brushing has been revised to ensure the client is assisted during this procedure. The staff has been in serviced and an in service on dental hygiene and tooth brushing and dental care has been completed by the nurse. See attached – in service sheet and IPP on tooth brushing	9/12/07
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, staff interviews and record review, the Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the client has successfully completed an objective identified in the IPP for two of the two clients in the sample. (Clients #2 and #3)	W 255		

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W 255	Continued From page 5 The findings include: 1. The facility's QMRP failed to revise Client #2's program objectives. a. On August 15, 2007 at 4:47 PM, Client #2 was observed receiving Haldol 4 mg, Trazodone HCL 200 mg and Zyprexa 15 mg. Interview with the Licensed Practical Nurse indicated that the aforementioned medications were used to manage the clients maladaptive behaviors to address physical and verbal aggression, stripping and repetitive behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) on August 16, 2007 at approximately 11:00 AM indicated that the client had a Behavior Support Plan (BSP) to address his maladaptive behaviors. Further interview with the QMRP indicated that the client has not displayed the maladaptive behaviors of physical and verbal aggression since the institution of one to one staffing support (June 2006). b. During the entrance conference on August 15, 2007, the QMRP indicated that Client #2 did not attend a day program, however the client received day programming services from the residential direct care staff. Review of the client's IPP dated March 8, 2007 revealed a program objective which stated, "[the client] will sweep the back porch of his home given verbal directives for three consecutive months by March 2008". Record verification of the data sheets from December 2006 through May 2007 indicated that the client achieved the established criteria since May 2007. 2. The QMRP failed to revise Client #1's IPP objective once the client met the established	W 255	W 255 a. Client # 2 has started a day program 5 days a week. He will continue to have a 1:1 staff to transition him into the day program for the next quarter, at which time his behaviors will be re evaluated and the need for a 1:1 staff will be re assessed. b. IPP for client #2 - for sweeping has been discontinued. In the future the QMRP will ensure that monthly documentation on IPP data will be included in the monthly QMRP notes. Data collected for each program will be monitored and documented to reveal the client's achievement and the programs, in which clients have achieved their objectives, are discontinued appropriately. The QMRP will ensure that all client programs are reviewed with the IDT at least every 6 mths to ensure that all clients receive the appropriate programs and program supplies and monitoring. The Agency has instituted a monthly QMRP Audit System to ensure that all client ISP/ IPP records are reviewed monthly. See attached Audit Record See attached – IPP discontinue Minutes from day program intake meeting	9/12/07

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W 255	Continued From page 6 criteria. Review of Client #1's IPP dated May 3, 2007 revealed a program objective which stated, "[the client] will sweep the front porch of his home when given verbal directives on 50% of the recorded trials for three consecutive months by May 2008". According to the data sheets from May 2007 through July 2007 revealed that the client achieved the established criteria in July 2007.	W 255		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, staff i interview, and record review, the facility failed Human Rights Committee (HRC) failed to review and approve the use of restrictive measures, for one of the two clients in the sample. (Client #2) The finding includes: During the entrance conference on August 15, 2007 at 9:35 AM, the Qualified Mental Retardation Professional (QMRP) stated that Client #2 had a Behavior Support Plan (BSP) and received psychotropic medication as well as one to one support services. During client observation from August 15 - 17, 2007, a direct care staff was observed with the client (at arms length) at all times.	W 262	W 262 Client # 1 – BSP has been revised to include a 1:1 staff. HRC has reviewed and approved the support services. See attached revised BSP and HRC approval record	9/12/07

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W 262	Continued From page 7 Review of the BSP dated March 3, 2007 address targeted behavior of verbal and physical aggression, stripping and repetitive behaviors. The BSP was designed to provide positive approaches to challenging behaviors so a successful home learning environment could be created. The BSP did not indicate a need for one to one support services. Review of the HRC minutes dated March 15, 2007 revealed that the client's BSP was review and approved by the HRC. It should be noted that the BSP approved did not include one to one support services. There no evidence that the HRC was made aware of the one to one staffing used to assist with the management of Client #2's behavior.	W 262		
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to store drugs under proper conditions of security. The finding includes: The facility failed to ensure that medications located in the refrigerator were stored under proper security. On August 15, 2007 at approximately 12:30 PM, a bottle of Tubersol PPD vials (2) and Hep B 1 ml vials (4) Tuberculin was observed in the	W 381	W 381 Nurses and staff were in serviced on medication storage. All medications needing refrigeration have been placed in a locked box in the refrigerator. Agency has instituted a monthly environmental audit system to ensure that environment / safety is maintained at all times and all medications are secured in a locked box. See attached in service record on medication storage and monthly environmental audit record	9/12/07

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W 381	Continued From page 8 refrigerator, unlocked. There was a label on the vials that indicated the medications were house stock. Interview with the Licensed Practical Nurse Coordinator indicated that the facility does not have a locked box to store the medications.	W 381		
W 393	483.460(n)(1) LABORATORY SERVICES If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure it met the requirements for performing glucose monitoring testing for one of two clients who requires glucose monitoring. (Client #2) The finding includes: During the evening medication administration observation on August 15, 2007 at 4:47 PM, the nurse was observed performing a fingerstick glucose test on Client #2 using a glucometer. Interview with the nurse and record verification on August 15, 2007, revealed that Client #2 was diabetic and was prescribed Glucophage 500 mg daily to treat this health condition. The client's glucose measurement of 130 mg. The nurse indicated that the primary care physician must be notified if the client's blood glucose measurement is less that 90 mg or more that 300 mg. Interview with the designated nurse and the review of records on August 16, 2007 at 11:00 AM revealed that the provider does not have a certificate of waiver as required by part 493 of the Clinical Laboratory Improvement Act (CLIA) to perform laboratory services, such as glucose monitoring in	W 393	W 393 The Agency is in the process of obtaining certification of waiver as required by the CLIA. The laboratory surveyor at the DOH has been contacted for this process.	9/13/07

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W 393	Continued From page 9 the facility. This information will be referred to the laboratory surveyor for review.	W 393		

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I 000	INITIAL COMMENTS A licensure survey was conducted from August 15, 2007 through August 17, 2007. The survey was initiated using the fundamental survey process. A random sample of two residents were selected from a population of four male residents with various degrees of disabilities. The findings of this survey were based on observations at the group home, one day program, interviews at both the group home and day program, review of clinical and administrative records to include the facility's unusual incident reports.	I 000		
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation and interview the GHMRP failed to lock caustic agents stored in the kitchen. The finding includes: During the environmental inspection on August 18, 2007 at approximately 1:10 PM revealed caustic agents were stored under the vanity in the upstairs bathroom unlocked.	I 095	I 095 All chemical have been removed from under the sink. Staff have been in serviced on client safety and OSHA regulations Agency has instituted a monthly environmental safety QA system. See attached monthly QA record, in service record for OSHA, safety	9/12/07
I 424	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (a) Has successfully completed an objective or	I 424		

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I 424	Continued From page 1 objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure habilitation and training was provided to its residents that would enable them to acquire and maintain life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. The finding includes: See Federal Deficiency Report - Citations W255	I 424	I 424 Refer to W 255	
I 432	3521.7(c) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care); This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure residents were effectively trained in hand washing, and tooth brushing. The finding includes: See Federal Deficiency Report Citation W227 and W242	I 432	I 432 Refer to W 227, W242	

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I 500	Continued From page 2	I 500		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the protections of each clients rights. The finding includes: See Federal Deficiency Report - CitationW126, W137, and W262	I 500	I 500 Refer to W 126, W137, W 262	

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R 000	INITIAL COMMENTS A licensure survey was conducted from August 15, 2007 through August 17, 2007. The survey was initiated using the fundamental survey process. A random sample of two residents were selected from a population of four male residents with various degrees of disabilities. The findings of this survey were based on observations at the group home, one day program, interviews at both the group home and day program, review of clinical and administrative records to include the facility's unusual incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions who have worked or resided within the seven (7) years. The finding includes: Review of the personnel files on August 18, 2007 at approximately 11:00 AM revealed the GHMRP failed to evidence criminal background checks for two direct care staff #4 and #11.	R 125	R 125 See attached criminal back ground checks for staff #4.The back ground check for staff #11 has been misplaced and the staff has been taken off the schedule till his back ground check has been completed. Agency has instituted a computerized staff data base to monitor all personnel records on a monthly basis to ensure that on going certifications and necessary clearances are always maintained in a current status	9/1207

Health Regulation Administration

Susan T. Sloan MN, BSN, MA TITLE VP (X6) DATE 9/6/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE